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# CLINICAL PERFECTIONISM: A CASE REPORT

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**Abstract.** The aim of this case report is to describe the impact of an intervention for clinical perfectionism, derived from a new cognitive-behavioural analysis, in a patient with binge eating disorder. It was hypothesized that clinical perfectionism was contributing to the maintenance of the eating disorder, and on this basis it was predicted that reducing clinical perfectionism would improve eating disorder psychopathology. Standardized independent assessments were found to be consistent with this hypothesis in that clinical perfectionism and eating disorder psychopathology improved over an eight-session intervention. Improvements were largely maintained at 5-month follow-up.

*Keywords:* Perfectionism, cognitive-behaviour therapy, theory, treatment, eating disorders.

## Introduction

Cognitive-behavioural approaches focusing on specific mechanisms of maintenance have yielded advances in the psychological treatment of disorders including panic disorder and bulimia nervosa (see Nathan & Gorman, 2002). Given this success, a cognitive-behavioural analysis focusing on the construct of "clinical perfectionism" has recently been proposed (Shafran, Cooper, & Fairburn, 2002). "Clinical perfectionism" is defined as "the over dependence of self-evaluation on the determined pursuit (and achievement) of self-imposed personally demanding, standards of performance in at least one salient domain, despite the occurrence of adverse consequences". (p. 773; Shafran et al., 2002). The over dependence of self-evaluation on pursuing and achieving such standards is regarded as the "core psychopathology" of clinical perfectionism, which is a more focused, specific clinical construct than "multidimensional perfectionism" (Shafran, Cooper, & Fairburn, 2003). A number of mechanisms are suggested to maintain clinical perfectionism including behaviour such as avoidance and repeated checking, dichotomous thinking operationalized as rigid rules, cognitive biases such as discounting success and overgeneralizing resulting in self-criticism and negative self-evaluation, and the raising of standards if they are achieved. In this analysis, it is suggested that in certain cases an eating disorder may be the expression of clinical perfectionism in the area of eating, shape weight or their control and, as such, clinical perfectionism may contribute to the maintenance of the eating disorder.

The interaction between Axis I psychopathology and clinical perfectionism is important in various respects. Perfectionism has been shown to impede the successful treatment

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of depression (Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998) and it may be a poor prognostic factor if the domain in which the clinical perfectionism is expressed overlaps with the domain of the Axis I psychopathology. There are few existing descriptions of cognitive-behavioural interventions for perfectionism. Those that exist do not focus on clinical perfectionism and do not address the relationship between Axis I psychopathology and perfectionism, which is a limitation since clinical perfectionism is not itself a psychological disorder.

The purpose of this case report is to describe the treatment of a patient with binge eating disorder using a focused intervention for clinical perfectionism. From the initial assessment and cognitive-behavioural formulation, clinical perfectionism appeared to contribute significantly to the maintenance of this patient's eating difficulties and she wanted a broad approach to overcoming the binge eating. The current intervention therefore aimed to improve the eating disorder by addressing the clinical perfectionism. The specific treatment intervention was derived from the cognitive-behavioural analysis of clinical perfectionism and focused on four components: 1) identifying clinical perfection as a problem; 2) broadening the patient's scheme for self-evaluation; 3) using behavioural experiments to test competing hypotheses; 4) using cognitive-behavioural methods to address personal standards, self-criticism and cognitive biases that maintain clinical perfectionism. Standardized measures of eating disorder psychopathology and clinical perfectionism were taken before and after treatment, and at 2 and 5-month follow-up.

## History and assessment by therapist

Barbara was a 26-year-old woman with a 7-year history of binge eating disorder. Her eating difficulties began with dietary restriction following weight gain after going to university. At that time she had managed to maintain her weight (BMI = 20) by alternating episodes of binge eating with severe dietary restriction. In the year previous to treatment, her dietary restriction had reduced but she was still having episodes of binge eating approximately four times weekly. Her BMI at assessment was 21.4. Assessment consisted of a detailed discussion of Barbara's current and previous eating difficulties, her physical status and co-morbid difficulties, family background and psychiatric history. Barbara described striving to attain a body like that of a puma, with no excess fat anywhere. She frequently avoided difficult situations in which she might "fail" and reacted to failure with self-criticism. Her thinking was often dichotomous and her standards were operationalized in the form of rigid rules regarding what was "right" and "wrong". Her binges would sometimes be triggered by negative mood states but more usually would be a response to feeling that things were not "right".

## Assessment by an independent assessor

Measures were taken before and after the intervention and again at 2- and 5-month follow-up. These included the Eating Disorder Examination (EDE; Fairburn & Cooper, 1993; the "gold standard" assessment measure), which includes four subscales: restraint, eating concern, shape concern and weight concern; the clinical perfectionism scale (Fairburn, unpublished); and the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). In addition, Barbara completed a body size estimation task (BSE; Shafran & Fairburn, 2002) which involves adjusting a "mirror-size" projected digital image whilst looking in the mirror

to (a) match what they actually see in the mirror and (b) how they would "like to look" in the mirror to obtain a desired body size (see Shafran & Fairburn (2002) for further information about this task).

## Treatment

Treatment comprised eight face-to-face sessions and two follow-up telephone sessions. First, a cognitive-behavioural formulation was drawn up in which it was agreed that clinical perfectionism was a problem that was contributing to the maintenance of the eating disorder by preventing feelings of calmness. Barbara felt that she lost control over her eating in response to this lack of inner calmness and attempted to regain inner calmness by controlling her environment and trying to ensure that things were "right". However, this resulted in numerous rules, judgments and elaborations in her head, and made her aware of what was "wrong", thereby preventing her from attaining inner calm. From this formulation it appeared that Barbara judged herself on her ability to be a calm, "centred" person and she strived to achieve this. She readily agreed that such a focus paradoxically prevented her from achieving her desired state. She agreed to try to broaden the way in which she evaluated herself by concentrating on other areas, such as her sense of humour and personality in general, and this was a key focus throughout treatment. A pie chart was drawn to illustrate the principle of judging oneself in many different areas as opposed to one.

Behavioural experiments were introduced. These primarily tested ideas concerning inner calmness and the effects of not trying to do things perfectly. For example, she predicted that she would feel better if she spent a long time and expended a great deal of effort checking an important e-mail than if she did it quickly and only read through it once. She tested this prediction by writing two e-mails of equal importance in different ways (with time and effort vs. quickly). She recorded her feelings of "calmness" before, immediately after, and 30 minutes after the e-mails were completed. To her surprise, "calmness" was greater after 30 minutes when she had written the e-mail quickly.

Other cognitive-behavioural methods to address her personal standards, self-criticism and cognitive biases included a continuum to modify all-or-nothing thinking, to transform rules into guidelines, to maintain a positive mood by doing pleasurable activities and to improve self-esteem by writing a positive data log (Fennell, 1999). The follow-up sessions involved a review of the progress of treatment and discussing ways of resolving difficulties.

## Outcome

Barbara's scores for clinical perfectionism, depression, and eating disorder symptoms and the BSE task are shown in Table 1. Table 1 indicates that Barbara's intervention for clinical perfectionism was successful and that her binge-eating decreased. She maintained her gains despite stressful situations in the 2-month and 5-month follow-up period. BSE scores indicate that she performed accurately in the body size estimation task, and her "desired" body size increased after treatment.

**Table 1.** Scores on measures of clinical perfectionism, depression, eating disorder symptoms and the body size estimation task before and after treatment and at follow-up

| | Before treatment | After treatment | 2-month follow-up | 5-month follow-up |
|---|---|---|---|---|
| Clinical Perfectionism | 27 | 5 | 8 | 13 |
| Beck Depression Inventory | 12 | 0 | 1 | 0 |
| Eating Disorder Examination: | | | | |
| Restraint | 3.4 | 0.8 | 0.8 | 0.4 |
| Weight concern | 4.0 | 2.0 | 0.0 | 2.0 |
| Shape concern | 3.9 | 1.8 | 0.5 | 2.0 |
| Eating concern | 2.0 | 0.2 | 0.2 | 0.8 |
| Number of OBE episodes[a] | 17 | 0 | 0 | 1 |
| Number of OBE days[f] | 8 | 0 | 0 | 1 |
| Body size estimation task: | | | | |
| "actual" size (as a %) | 104 | 111 | 102.5 | 98.5 |
| "desired" size (as a %) | 82 | 91.5 | 94.5 | 94 |

[a] Number of objective bulimic episodes occurring during the previous 4 weeks.
[b] Number of days with at least one objective bulimic episode during the previous 4 weeks.

## Discussion and conclusions

This is a case report of a theory-driven intervention for clinical perfectionism. At the end of treatment, both clinical perfectionism and binge eating disorder had significantly reduced. However, this case study has a number of limitations. First, because of Barbara's preferences, an evidence-based approach to the binge eating was not tried first, so it is possible that clinical perfectionism would not have impeded the progress of standard treatment for her eating disorder. It is clearly better only to introduce a novel treatment after the failure of an evidence-based one.

Second, it is not possible to demonstrate unequivocally that it was the intervention for clinical perfectionism that produced the change in the binge-eating. This is particularly important since binge eating has been shown to show a fluctuating natural course and there have been several randomized controlled trials of interventions in binge eating disorder all of which are successful in reducing binge eating in a high proportion of cases (see Nathan & Gorman, 2002). Indeed, it has been said that the real challenge in the treatment of binge eating disorder is to find a treatment that does *not* work. Furthermore, since this is a single case report, it is also not possible to conclude that the specified intervention was responsible for the change in clinical perfectionism; the passage of time, non-specific aspects of treatment, or the improvement in binge eating may all have contributed to the improvement in scores of clinical perfectionism. However, many clinicians would agree that Barbara's longstanding type of clinical perfectionism, characterized by rigidity and rules, rarely dissipates spontaneously. It is therefore plausible to suggest that the intervention for clinical perfectionism appeared to be effective in Barbara's case, and it is plausible that it is this intervention that led to the sustained improvement in her binge eating at the end of treatment and at follow-up.

Third, the measure of clinical perfectionism has not been validated. However, there was no previous measure of this newly specified construct clinical perfectionism. Existing measures

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of "multidimensional perfectionism" assess a different construct and are not designed to be sensitive to clinical change and other measures such as the "dysfunctional attitudes scale" also assess a different construct to the one under investigation. The measure of clinical perfectionism is in the process of being validated.

Fourth, it can be seen from Table 1 that clinical perfectionism scores appear to be increasing steadily during the 5 months after treatment. A longer follow-up period would help determine the stability of the intervention for clinical perfectionism.

Strengths of the study include the use of an independent assessor to determine eating disorder symptoms, the use of well-validated measure for this Axis I psychopathology, and the implementation of a standard, theory-driven protocol for the treatment of clinical perfectionism.

In summary, this paper describes the treatment of binge-eating disorder using an intervention for clinical perfectionism. It is hoped that such an intervention may have utility when clinical perfectionism appears to be a factor in the maintenance of Axis I psychopathology and a barrier to change.

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